Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ALLIED MEDICAL CENTERS PO BOX 24809 HOUSTON TX 77029	MFDR Tracking #: M4-11-1544-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: CITY OF HOUSTON Box #: 29	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reason for denial of your EOB states: Pre-Authorization not obtained. Attached is a copy of the Pre-Authorization. Please note the start and end date. Our charges are well within the pre-auth period."

Amount in Dispute: $226.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the Medical Dispute Resolution DWC-60 concerning claimant [injured employee] from Allied Medical – Avant Medical Group for date of service 07-19-10. Based on the submitted documentation, no further allowance is being recommended at this time per the following –

- Date of Service concerning MDR is 07-19-10
- Preauthorization request date is 07-15-10
- Determination date is 07-20-10
- Dates Certified for treatment of 07-20-10 through 08-19-10

Therefore, the date of service (07-19-10) is prior to the dates certified for treatment (07-20-10 through 08-19-10). No additional allowance is be [sic] recommended at this time."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
7/19/10	99212	N/A	$58.00	$0.00
7/19/10	97110, 97112, 97140	N/A	$168.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 9/21/2010
   - 50-These are non-covered services because this is not deemed a medically necessity with the Official Disability Guidelines
   - 197-Percertification/ authorization/ notification absent

Issues

1. Did the requestor obtain preauthorization for the physical therapy services in accordance with 28 Tex. Admin. Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule 134.600 (p)(5)(A), states: "Non-emergency health care requiring preauthorization includes: physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning;
   (iii) Orthotics/Prosthetics Management;
   (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code;
2. Review of the IMO Pre-Authorization Determination Letter, dated 7/20/2010 indicates that preauthorization was approved for 2 sessions of physical therapy at 2 times a week for 1 week – lumbar to be done on an outpatient basis. The certified dates of services are 7/20/10 to 8/19/10. The disputed dates of services is dated 7/19/2010 one day before the authorization start and end timeframe. No other documentation was submitted to support that the disputed date of service of 7/19/2010 was preauthorized, therefore reimbursement cannot be recommended for CPT codes 97110, 97112 and 97140.
3. The requestor billed CPT code 99212 which was not covered by the preauthorization letter dated 7/20/2010, the insurance carrier denied this charge with denial explanation: "50-These are non-covered services because this is not deemed a medically necessity with the Official Disability Guidelines." And "197-Percertification/ authorization/ notification absent." Per rule 133.305 ((b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021." The requestor did not submit documentation to support that the medical necessity issue was resolved prior to the submission of the medical fee dispute. Therefore per rule 133.307 (e) (3) (G), this CPT code is not eligible for review by the medical fee dispute resolution section and should be adjudicated under the provisions of rule 133.308. Therefore, reimbursement is not recommended for CPT code 99212.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	February 11, 2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.